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ABSTRACT

Psychotherapists of different theoretical persuasions use systematically different profiles of verbal response modes. However, clients tend to use very similar profiles, regardless of what their therapist does. Disclosure comprises the largest part of this common client profile, and it distinguishes the client role from other roles. Higher levels of client disclosure are associated with external observers' ratings of good psychotherapeutic process, though not necessarily with participants' ratings of session depth and value. Relatively high levels of client disclosures are associated with participants' judgments that a session was relatively rough, difficult, and dangerous. And clients who are more depressed, anxious, or generally psychologically distressed have higher levels of disclosures in psychotherapy. A helpful analogy suggests that client disclosure may be related to psychological disturbance as body temperature and white blood cell count are to physical infection. In the case of physical infection, a fever and an elevated leukocyte level are parts of the body's immunological response--mobilizing to fight the infection. Disclosure may be, analogously, part of a natural corrective or protective reaction to psychological disturbance. Primarily, it helps regain psychological homeostasis, and secondarily, it serves as a symptom of distress. This analogy makes sense of the distinctively high level of disclosures in therapy and of the theoretical and empirical association of disclosures with "good process". It is also consistent with the correlation of disclosures with psychological distress and discomfort. (Author/JAC)

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Client Self-Disclosure in Psychotherapy

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Abstract

Self-disclosure is a primary component of the psychotherapy client's role. High levels correlate with observers' judgments of "good process," but not necessarily with clients' or therapists' judgments of session value or with outcome measures. An adequate model must incorporate client differences in psychological distress and comfort with self-exploration.

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Client Self-Disclosure in Psychotherapy

William B. Stiles

Calling psychotherapy "the talking cure" suggests that there is something therapeutic in the verbal exchange between client and psychotherapist. My collaborators and I have studied the talk in psychotherapy, with a long-range interest in finding what about the talk is beneficial.

The work I will review here has considered psychotherapeutic process on an utterance-by-utterance basis. I am aware that this molecular approach may miss some of the more global, synthetic properties of psychotherapy. Nevertheless, we have found some interesting orderliness at this level of analysis. Our findings have tended to focus our attention on one type of talk in psychotherapy: client Disclosure.

Definition of Disclosure

Definitions of self-disclosure are often based on the content of what is said--whether it seems personal or potentially embarrassing. In my work, I have used a epistemological definition, derived from a general-purpose taxonomy of verbal response modes (Stiles 1978, 1979, 1981a). The definition has three parts, each of which is based on the dichotomy of speaker versus other, that is, of communicator versus intended recipient. The taxonomy is outlined in Table 1.

First, a Disclosure's topic is the speaker's experience. That is, it concerns information held by the speaker rather than information held by the other. This principle distinguishes Disclosure from such utterances as Questions or Rogerian Reflections, which have the other person's experience as their topic.

Second, Disclosure requires no specific presumptions about what the other's experience is, or what it should be, or what the other should do. This distinguishes Disclosures from directives (called "Advisements" in Table 1), such as commands, requests, or suggestions, which are the speaker's idea (that is, they concern the speaker's experience), but which do presume to impose that idea on the other (e.g., "close the door."). We say Disclosures are "focused on the speaker," whereas Advisements are "focused on the other," as are Interpretations and Reflections, which also require presumptions about the other person's experience.

Finally, Disclosures use the Speaker's internal frame of reference rather than an external, generally shared frame of reference. That is, the truth of a Disclosure depends on epistemologically private knowledge held by the speaker; it is not decidable on the basis of information accessible to others. The frame of reference test distinguishes Disclosures from Edifications, which are objective or factual statements, that is, statements which concern information held by the speaker (speaker's experience) and which make no particular presumptions about the other (focus on speaker), but which use an external perspective.

Table 1: Taxonomy of Verbal Response Modes

	Speaker's frame of reference	Other's frame of reference
Speaker's experience		
Focus on speaker	Disclosure (D)	Edification (E)
Focus on other	Advisement (A)	Confirmation (C)
Other's experience		
Focus on speaker	Question (Q)	Acknowledgment (K)
Focus on other	Interpretation (I)	Reflection (R)

Source: Stiles, W. B. Psychiatry, 1979, 42, 49-62.

Table 2: Examples of Exposition Modes

	Disclosure intent (speaker's internal frame of reference)	Edification intent (external, objective frame of reference)
Disclosure form (first person declarative)	I feel frightened. D(D)	I left early. D(E)
	I hear a voice. D(D)	I said I loved her. D(E)
	I don't know. D(D)	I'm out of work. D(E)
Edification form (third person declarative)	It frightens me. E(D)	Socrates was a man. E(E)
	Strawberry is my favorite. E(D)	She said she loved me. E(E)
	She is always on my mind. E(D)	Both of them were there. E(E)

The Disclosure-Edification distinction is basically between subjective versus objective statements. For example, to know the truth of "I feel depressed" or "I prefer strawberry to vanilla," you have to be inside the speaker's head; hence these are Disclosures. In fact, the proper test for a Disclosure's felicity is technically sincerity rather than truth. By contrast, the truth of "The cat is on the mat" or "Today is May 5th" are decidable without access to the speaker's private experience, so they are Edifications.

Edifications do not have to be true or emotionally neutral. "The cow jumped over the moon" and "My parents are getting divorced" are Edifications. Similarly, Disclosures do not have to be sincere or affectively charged. Statements of perception such as "I hear water dripping" and statements of intention such as "I'm going to call her this afternoon," are Disclosures because one cannot know for sure what other people perceive or intend unless you can read their minds.

Making these distinctions is not always simple, but coders can learn to make them reliably, even in the fragmented, ungrammatical speech of natural conversations.

The verbal response mode coding system actually classifies each utterance twice, once according to its intended meaning, as I have described, and once according to its grammatical form. For Disclosure and Edification, the form distinction is relatively simple: Disclosure is declarative and first person (i.e., the subject is "I") whereas Edification is declarative and third person ("he," "she," "it," etc.). An utterance's form and intent may be the same ("pure modes") or different ("mixed modes").

As a notational convention, we write the form symbol first and the intent symbol in parentheses. Thus "He made me mad" is Edification form with Disclosure intent, written E(D) and read "Edification in service of Disclosure."

Table 2 illustrates the four pure and mixed combinations of Edification and Disclosure. These are called the exposition modes because they comprise the bulk of most expository discourse (see also Stiles, Putnam & Jacob, 1982).

Is There a Common Core to Psychotherapeutic Process?

I was led to study client Disclosure by a series of results that began with an interest in psychotherapists' verbal techniques. In one study (Stiles, 1979) we coded therapists' utterances in transcripts of three types of psychotherapy: Client-centered, Gestalt, and psychoanalytic. The transcripts were of actual therapy sessions that were teaching examples by prominent practitioners of each school--Carl Rogers, Fritz Perls, Franz Alexander, and so forth. The results showed dramatic and very systematic differences in mode use across schools.

Client-centered therapists used modes in the client's frame of reference (the right half of Table 1), mostly Acknowledgments (e.g., "mm-hm," "yeah") and Reflections. This is consistent with Carl Rogers's (1951) injunction to "assume the internal frame of reference of the client--to perceive the world as the client sees it."

Gestalt therapists used modes in the therapists frame of reference (the left half of Table 1), including Advisements ("Give your stomach a voice"), Interpretations ("You are a phony"), Disclosures and Questions. This is consistent with Fritz Perls's (1969) injunction to stay in the "now," which is the therapists' existential frame of reference.

Psychoanalytic therapists used modes that concerned the patient's experience (the lower half of Table 1), a different slice of the taxonomic cube that includes Interpretations, Reflections, Questions, and Acknowledgments. This follows Sigmund Freud's (1912/1958) injunction to "be opaque and, like a mirror, show nothing but what is shown to you."

Within each school, therapists complied with these differing theoretical injunctions, as translated into the taxonomic principles, for 80% to 90% of their utterances (Stiles, 1979).

These results are interesting in several respects, but I would like to focus on one implication: If there is a common core in the verbal interaction of different psychotherapies, it is not likely to be found in the therapists' verbal behavior. All of the therapists we studied were highly respected clinicians, and it seems unreasonable to attribute their common success to the very small overlap in their verbal techniques.

In contrast to the diversity of therapists' verbal techniques, clients use a remarkably consistent profile, regardless of their therapist's theoretical orientation. We coded client utterances in as diverse a set of transcripts as those we used to show therapist differences and found client mode use virtually the same across schools (Stiles & Sultan, 1979). The average client profile, shown in the first column of Table 3, consists mainly of the four exposition modes I described earlier--utterances that are Disclosure or Edification in form and in intent.

Together, the exposition modes typically account for at least 75% of client utterances. Another 10%-15% are Acknowledgment forms--such as "mm-hm," "oh," "yes," and "no." The latter are used with varying intents, including pure Acknowledgments of therapists' communication, confirmation or agreement with therapists' remarks, or answers to therapists' closed questions. The remaining utterances are in modes that vary a good deal from client to client.

The consistency of the high proportion of exposition modes is striking. It suggested to me that if there is a common core to the verbal psychotherapies, it is more likely to be found in the client's behavior than in the therapist's.

Table 3 compares the average mode profile of clients in psychotherapy (Stiles & Sultan, 1979) with two superficially similar profiles: strangers in casual conversations (Premo & Stiles, in press) and patients in the medical history-taking portion of initial medical interviews in a hospital clinic (Stiles, Putnam, & Jacob, 1982). The most obvious distinction of the client profile is the high percentage of Disclosure. By contrast, strangers used more Edifications, and more Acknowledgments and Questions as they traded off being attentive to what their partners were saying. Medical patients used more K(D) and K(E). These are yes/no answers to closed Questions asked by the physician. Thus, although the medical patient role is superficially similar (and historically related to) the psychotherapy

Table 3:

Verbal Response Mode Profiles of Clients in Psychotherapy, Strangers in Casual Conversations, and Patients Giving Their Medical Histories

Mode	Clients in Psychotherapy[a]	Strangers in Casual Conversations[b]	Patients Giving Medical Histories[c]
D(D)	37.9	11.7	14.8
E(D)	22.9	6.2	13.6
D(E)	4.7	10.0	19.2
E(E)	10.7	22.4	15.2
K(K)	3.4	17.5	3.6
K(C)	4.2	1.4	3.2
K(D)	3.0	.8	5.4
K(E)	.3	2.4	10.6
Q(Q)	1.8	5.4	.8
Other	11.1	22.2	13.6
Total	100.0	100.0	100.0

Mode abbreviations: D = Disclosure, E = Edification, K = Acknowledgment, C = Confirmation, Q = Question. Form is written first, intent in parentheses. Other includes modes averaging less than 3% of utterances by all groups.

[a] from Stiles, W. B., & Sultan, F. E. Journal of Consulting and Clinical Psychology, 1979, 47, 611-613.

[b] from Premo, B. E., & Stiles, W. B. Journal of Social and Clinical Psychology, in press.

[c] from Stiles, W. B., Putnam, S. M., & Jacob, M. C. Health Psychology, 1982, 1, 315-336.

client role, it differs substantially in the degree to which there is a sustained, discursive exploration of subjective material. This exploration averages over half of all client utterances, if you count both D(D) and E(D) (cf. Table 2).

The prevalence of client Disclosure in psychotherapy may not be surprising; after all, one goes to psychotherapy to talk about feelings. However, these results indicate that it is distinctive among the relationships one normally encounters.

Correlates of Client Disclosure

There is variation from client to client and from session to session in how much Dislosure a client uses. In several studies, we have examined correlates of the percentage of a client's utterances that are Disclosures or Edifications. In reviewing these studies, it is helpful to think of a continuum of subjectivity of client discourse--from pure Disclosure to pure Edification, with the mixed modes E(D) and D(E) as intermediate.

One finding has been that the percentage of client utterances coded Disclosure is correlated with ratings of good psychotherapeutic process. Table 4 summarizes evidence on this point from two studies.

The first study (Stiles, McDaniel, & McGaughey, 1979) compared mode percentages with ratings on the experiencing scale in 90 brief segments of interviews. The experiencing scale was developed to measure the primary client process variable in client-centered theory; it "attempts to assess the degree to which the patient communicates his personal, phenomenological perspective and employs it productively in the therapy session" (Klein, Mathieu, Gendlin, & Kiesler, 1969, p. 1).

The second study (McDaniel, Stiles, & McGaughey, 1981) compared client mode percentages in three whole sessions from each of 31 clients, sampled from courses of short term therapy, with ratings of segments of those 31 therapies on the Vanderbilt Psychotherapy Process Scale (as used by Gomes-Schwartz, 1978). This instrument yielded several factor-based indexes, including one called patient exploration and one called therapist exploration, which appear to measure the degree to which patients or therapists probed the inner meanings of the material brought by the patient. These "exploration" measures assess good process from a more psychodynamic perspective.

As Table 4 shows, pure Disclosure was positively correlated with experiencing and exploration, whereas pure Edification was negatively correlated with both. Correlations with the mixed modes E(D) and D(E) were intermediate. This suggests that client Disclosure, as opposed to Edification, is a major part of what psychologically sophisticated raters consider to be good process. (Note: the experiencing and exploration raters in these studies were clinical psychologists or graduate students in clinical psychology.)

I think the notion that client Disclosure represents good process is consistent with theoretical ideas from a variety of perspectives (Bordin, 1966; Gendlin & Tomlinson, 1967; Jourard, 1968, 1971; Kiesler, 1971). There is thus some consensus among observers and theorists that talking about thoughts and feelings is productive, whereas talking about facts is not.

Table 4:

Correlations of Client Disclosures and Edifications
With "Good Process" Ratings

	Client Mode Percentage	
	D(D)	E(E)
Experiencing Scale[a]	.58*	-.48*
Patient Exploration[b]	.66*	-.53*
Therapist Exploration[b]	.65*	-.56*

Note: D(D) = pure disclosure; E(E) = pure edification

*p < .01

[a]Stiles, W. B., McDaniel, S. H., & McGaughey, K. Journal of Consulting and Clinical Psychology, 1979, 47, 795-797.

[b]McDaniel, S. H., Stiles, W. B., & McGaughey, K. Journal of Consulting and Clinical Psychology, 1981, 49, 571-582.

Table 5:

Residual Correlations of Client Mode Use with Session
Evaluation Questionnaire Indexes in 47 Sessions,
Controlling for Mean Differences Among the 13 Client-Therapist Dyads

	Client Mode Percentage	
	D(D)	E(E)
Client SEQ Indexes		
Depth	.01	-.06
Smoothness	-.41*	.27
Therapist SEQ Indexes		
Depth	.13	.00
Smoothness	-.47**	.25

*p < .05 **p < .01 df = 33

Curiously, client Disclosure may not be related to the participants' ratings of the depth and value of their sessions. This suggestion is based on a study of clients' and therapists' post-session ratings on the Session Evaluation Questionnaire (SEQ; Stiles, 1980; Stiles & Snow, 1981), a brief bipolar adjective checklist that yields two independent factor-based evaluative dimensions, called depth and smoothness.

The depth dimension discriminates sessions described as deep, valuable, full, special, powerful, and good from sessions described as shallow, worthless, empty, ordinary, weak and bad. The smoothness dimension discriminates sessions described as smooth, comfortable, relaxed, easy, pleasant and safe from sessions described as rough, uncomfortable, tense, difficult, unpleasant, and dangerous.

In a study of 47 sessions taken from the ongoing therapy of 13 client-therapist dyads (M = 3.6 sessions per dyad), client mode use was compared with client and therapist SEQ ratings (Stiles, 1981b, in preparation). Table 5 shows the residual correlations, across sessions, of client percentage of D(D) and E(E) with client and therapist SEQ indexes, after controlling for mean differences among the 13 dyads. That is, these correlations assess the relation of depth and smoothness to Disclosure across each client's sessions, not across clients.

The results, which are preliminary, show that sessions relatively high in client Disclosures were not judged deeper, or more valuable by either clients or therapists. This seems contrary to the judgment of external observers, if ratings of depth and value are taken as equivalent to ratings of experiencing and exploration.

On the other hand client Disclosures were negatively correlated with SEQ smoothness, as rated from both perspectives. That is, sessions relatively high in client Disclosures were judged as relatively rough, uncomfortable, difficult, and dangerous by both participants.

There is also evidence that, across clients, a tendency to use a high percentage of Disclosures is associated with greater psychological disturbance and distress. Table 6 gives some illustrative correlations (from McDaniel et al., 1981) of clients' average mode use (based on 3 sessions) with measures taken at intake, termination, and one-year follow-up, from three different perspectives, the client's, the therapist's, and that of an independent clinician who interviewed and rated the clients. These results are consistent with observations by other researchers of associations of higher levels of self-disclosure (defined variously) and self-references with greater psychopathology (Coyne, 1976; Mayo, 1968; Persons & Marks, 1970; Stanley & Bownes, 1966; Weintraub, 1981; Wortman & Dunkel-Schetter, 1980).

This same study (McDaniel, et al, 1981), which was based on data collected in the Vanderbilt Psychotherapy Project (Strupp & Hadley, 1979) failed to find any association of percent Disclosure or Edification to measures of improvement in psychotherapy. Indeed it has in general proved extremely difficult to establish simple process-outcome relationships (Orlinsky & Howard, 1978). There are a variety of methodological excuses for this difficulty, but I think there may be some important conceptual problems as well.

Table 6

Verbal Response Mode Correlates of
Measures of Psychological Disturbance and Distress Taken
at Intake, Termination, and One-Year Follow-up

	Correlations with Percent D(D)			Correlations with Percent R(E)		
	Intake	Termination	Follow-up	Intake	Termination	Follow-up
Client's Perspective						
MMPI Depression Scale	.53**	.51**	.34	-.42*	-.44*	-.36
Rating of "Happiness Now"	-.17	-.39*	-.05	.58**	.56**	.45*
Therapist's Perspective						
Health-Sickness Rating Scale	.56**	.49**	--	-.19	-.21	--
Distress Rating Cluster	.49**	.48**	--	-.28	-.16	--
Independent Clinician's Perspective						
Health-Sickness Rating Scale	.32	.24	.27	-.51**	-.30	-.31
Subjective Distress	.51**	.51**	.39	-.47**	-.44*	-.45*

N varies from 22 to 31 because of missing data on some scales.

*p < .05 **p < .01

Source: McDaniel, S. H., Stiles, W. B., & McGaughey, K. J. Journal of Consulting and Clinical Psychology, 1981, 49, 571-582.

Summary and Synthesis

Psychotherapists of different theoretical persuasions use systematically different profiles of verbal response modes. However, clients tend to use very similar profiles, regardless of what their therapist does. Disclosure comprises the largest part of this common client profile, and it distinguishes the client role from other roles. Higher levels of client Disclosure are associated with external observers' ratings of good psychotherapeutic process, though not necessarily with participants' ratings of session depth and value. Relatively high levels of client Disclosures are associated with participants' judgments that a session was relatively rough, difficult, and dangerous. And clients who are more depressed, anxious, or generally psychologically distressed have higher levels of Disclosures in psychotherapy.

This story has many loose ends, and I can't tie them all together. However, I do have an analogy that has been helpful to me: client Disclosure may be related to psychological disturbance as body temperature and white blood cell count are to physical infection.

In the case of physical infection, a fever and an elevated leukocyte level are parts of the body's immunological response--mobilizing to fight the infection. I am suggesting that Disclosure may be, analogously, part of a natural corrective or protective reaction to psychological disturbance. Primarily it helps regain psychological homeostasis, and secondarily it serves as a symptom of distress.

In effect, I am suggesting that when people are upset, they have a natural tendency to talk more about their thoughts and feelings than about facts. To put it another way, they are trapped in their own frame of reference, and they need to express their inner turbulence as a way of understanding it and reconciling their experience with their sense of self. Psychotherapy offers a relationship in which this tendency to disclose can be expressed and even encouraged, in which troubled people can come to terms with the upsetting forces in their lives by examining their own subjective responses to them.

This analogy makes sense of the distinctively high level of Disclosures in therapy and of the theoretical and empirical association of Disclosures with "good process" is also consistent with the correlation of Disclosures with psychological distress and discomfort.

With a little bit of stretching, the analogy suggests some qualifications to the simplistic notion that Disclosure is good for everybody. According to the analogy, a high level of Disclosure is a specific restorative response to psychological distress. People who are not upset would not necessarily benefit from Disclosure, just as people who do not have a physical infection would not necessarily benefit from a fever or an elevated leukocyte level.

Clearly, some people who show up in therapy are blocked in their ability to Disclose, even though they are upset, perhaps because of early training for stoicism or constricting social norms. In terms of the analogy, it is as if they had acquired an immune deficiency, an inability to react restoratively to psychological upset. For such people, training in Disclosure, such as that offered by Gendlin (1978), should be highly beneficial.

The analogy also helps account for the inconsistency of process-outcome results. People who are more disturbed tend to Disclose more, whereas they do not necessarily improve more in therapy. Consequently, correlations of Disclosure and improvement get muddled. By analogy, one would not expect measures of recovery from physical infection to be correlated with degree of elevation in body temperature or leukocyte level, even though these may be central to the process of recovery.

I think sorting this out empirically will take some ingenuity. At the least, an adequate model will have to take into account individual difference in degree of disturbance and in comfort with Disclosing. But the complexity should not be allowed to obscure the centrality of Disclosure's role in psychotherapy.

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